

***United States Court of Appeals
for the Second Circuit***



**APPELLANT'S
BRIEF**

75-6128

United States Court of Appeals
FOR THE SECOND CIRCUIT

GREATER NEW YORK HOSPITAL ASSOCIATION and PEN-
INSULA HOSPITAL CENTER, on behalf of themselves and
all other voluntary non-profit hospitals which are members of
GREATER NEW YORK HOSPITAL ASSOCIATION and
which are reimbursed for Medicare services rendered to hos-
pital patients under the Periodic Interim Payments Plan
established in 1968,

Plaintiffs-Appellants,

UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL,
PHELPS MEMORIAL HOSPITAL ASSOCIATION, COM-
MUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY,
THE CORNWALL HOSPITAL, NORTHERN DUTCHESS
HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL,
WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST.
CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH
NASSAU COMMUNITIES HOSPITAL, NORTH SHORE
HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL,
LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE
HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTING-
TON HOSPITAL, SOUTHAMPTON HOSPITAL, COM-
MUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS
HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST.
JOSEPH'S HOSPITAL OF YONKERS AND CENTRAL
SUFFOLK HOSPITAL ASSOCIATION,

Intervenor Plaintiffs-Appellants,

—against—

DAVID MATTHEWS as Secretary of the UNITED STATES
DEPARTMENT OF HEALTH, EDUCATION AND WEL-
FARE, and JAMES B. CARDWELL, as United States Com-
missioner of Social Security,

Defendants-Appellee

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

INTERVENOR PLAINTIFFS-APPELLANTS' BRIEF

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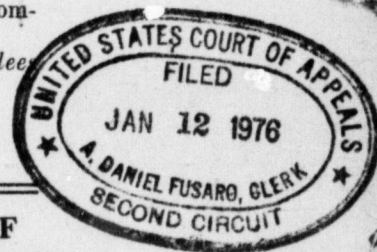


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UNITED STATES COURT OF APPEALS
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NO. 75-6128

GREATER NEW YORK HOSPITAL ASSOCIATION and PENNINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary non-profit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs-Appellants,

UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,

Intervenor Plaintiffs-Appellants,

- against -

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants-Appellees

BRIEF OF INTERVENOR PLAINTIFFS-APPELLANTS

ISSUE PRESENTED FOR REVIEW

Whether the Court below committed error in holding the Administrative Procedure Act (5 U.S.C. §701) prohibits judicial review of a regulation promulgated by the Secretary of Health, Education and Welfare, where implementation of that regulation would cause irreparable injury in fact to the not-for-profit hospitals affected thereby.

STATEMENT OF THE CASE

This is an appeal from an order of the United States District Court for the Southern District of New York (Metzner, J.) rendered December 11, 1975, dismissing the complaints of plaintiffs and intervenor-plaintiffs (hereinafter referred to collectively either as "appellants" or "the hospitals").

The fundamental issue presented on this appeal is whether a determination by the Secretary (hereinafter referred to as "the Secretary") of Health, Education and Welfare (hereinafter referred to as "HEW") to substitute for a long-standing method of Medicare reimbursement to appellants a new system of reimbursement which would jeopardize at best and undermine at worst appellants' financial viability, is subject to judicial review. As the record amply demonstrates, such adverse impact on appellants' existing precarious

financial condition will result in either a curtailment of services now rendered,¹ or in a diminution in the quality of care rendered.²

Appellants are voluntary or not-for-profit hospitals which, starting in 1968, have been reimbursed for treating patients covered under the Medicare program (42 U.S.C. 1395 et seq.) by means of the original Periodic Interim Payments method (hereinafter referred to as "Old PIP"). Pursuant to this method, appellants receive weekly payments from HEW. These payments are received on the average of three days after services have been rendered to Medicare patients.

Prior to the promulgation of Old PIP, all hospitals rendering treatment to Medicare patients were reimbursed by HEW only after the submission of individual hospital bills evidencing such treatment. By 1967, it was evident that, at least with respect to hospitals located in the greater New York metropolitan area, this system of reimbursement was resulting in long delays between a hospital's rendering of services and reimbursement therefor. Accordingly, beginning on January 1, 1968, HEW allowed hospitals to elect an alternative method of reimbursement -- i.e., to re-

1. See, e.g., Testimony of Philip C. Abrams, Appendix, 147a and 150a (hereinafter, references to the Appendix are designated (A a)).

2. See, e.g., Testimony of Peter B. Terenzio (A183a).

ceive on a weekly basis 1/52 of their estimated annual Medicare reimbursement.

On January 29, 1973 the Secretary announced that hospitals which had not as of that date elected to be reimbursed pursuant to Old PIP, could no longer do so. In June of 1973, this "moratorium" on Old PIP was extended until further notice.

On September 1, 1973, a new PIP method (hereinafter referred to as "New PIP") was proposed, which provided for bi-weekly payments to be made, no sooner than two weeks after the end of the service period during which care was rendered. As a result, payments under New PIP would be made on an average of three weeks after the rendering of services to Medicare patients.

On July 16, 1975, the final regulation creating New PIP was published (20 C.F.R. 405.454(j)) (40 Fed. Reg. 29815 (1975)). Pursuant to this new regulation, hospitals which had previously elected to be reimbursed under Old PIP (weekly) were required to convert to New PIP by September 15, 1975.

Thereafter, on September 2, 1975 the Secretary, while conceding that immediate implementation of New PIP would "create extraordinary cash flow problems for... hospitals... located in urban centers..." (40 Fed. Reg. 40192 (1975)), did not retract New PIP -- he merely postponed its implementation until May 31, 1976.

ARGUMENT

THE SECRETARY'S PROMULGATION OF
NEW PIP IS SUBJECT TO JUDICIAL
REVIEW

The Secretary promulgated New PIP pursuant to 42 U.S.C. §1395g which provides, in pertinent part, as follows:

The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments....

The Court below found that implementation of New PIP will forever bar the hospitals' use of approximately thirty million dollars in cash flow by May of 1976 (A319a) resulting in a probable curtailment of services and a diminution in the quality of care rendered by the hospitals. Notwithstanding this injury in fact to appellants, and the ensuing harm to the people of the State of New York, the Court below refused to review the Secretary's action, solely because the Secretary's promulgation of New PIP was held

to be "committed to agency discretion by the statute" (A319a). The Court below concluded, for this reason alone, that "[j]udicial review is barred by [5 U.S.C.] section 701." (id.)

In Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402 (1971), the Supreme Court stated that the "committed to agency discretion" exception to judicial review "is a very narrow exception", 401 U.S. at 410, and, relying on Abbott Laboratories v. Gardner, 387 U.S. 136, 141 (1967), held that unless there is "'clear and convincing evidence' of a ... legislative intent to restrict access to judicial review", 401 U.S. at 410, agency action must be subject to such review.

The Court below found:

In the instant case, there is no clear and convincing showing of a legislative intent to prohibit judicial review. (A318a)

Accordingly, it was error for the Court below to decline jurisdiction of this case and to dismiss the complaint. See also Association of Data Processing Service Organizations, Inc. v. Camp, 397 U.S. 150 (1970); Barlow v. Collins, 397 U.S. 159 (1970); Kletschka v. Driver, 411 F. 2d 436 (2d Cir. 1969); Cappadora v. Celebrezze, 356 F. 2d 1 (2d Cir. 1965); Littell v. Morton, 445 F. 2d 1207 (4th Cir. 1971); Scanwell Laboratories, Inc. v. Shaffer, 424 F. 2d 859 (D.C. Cir. 1970).

Moreover, this Court has held on at least two separate

occasions that the Secretary's actions affecting the manner and method of Medicare reimbursement to health facilities pursuant to 42 U.S.C. §1395g (the same statute under which the PIP regulations were promulgated) and 42 U.S.C. 1395x(v) were not so committed to agency discretion (i.e. HEW) as to preclude judicial review. Aquavella v. Richardson, 437 F. 2d 397 (2d Cir. 1971); Kingsbrook Jewish Medical Center v. Richardson, 486 F. 2d 663 (2d Cir. 1973).

In Aquavella, the Secretary, purportedly pursuant to 42 U.S.C. 1395f(b), g, u, and x, suspended Medicare payments to the Glen Oaks Nursing Home by reason of HEW's alleged prior overpayments to it, and various violations of the Medicare Act by the owners of the facility. An action was then brought in the District Court for an order reinstating the Medicare payments. The Western District dismissed the complaint on the ground that the Secretary's suspension of Medicare payments was not subject to judicial review.

On appeal, the issue before this Court was articulated as "whether a district court has jurisdiction to review the Secretary's decision... to suspend payments to a provider under the Medicare Act." 437 F. 2d at 400. This Court reversed the dismissal of the action and stated:

Although quoting section 10(a)(2) of the APA, 5 U.S.C. §701(a)(2), in [his] brief, [the Secretary does] not appear to argue that review under section 10 of the APA is barred because the Medicare Act "so far" commits the

agency action (suspension of payments) "to agency discretion" that the suspension could not be reviewed even if there were a clear abuse as to authority or procedure. In any event, if [the Secretary is] so arguing, we do not accept that construction here. (emphasis supplied)
437 F. 2d at 401.

We submit that if the Secretary's determination to suspend Medicare payments to a health facility may be judicially reviewed, a fortiori his promulgation of a regulation which, if implemented would, in effect, permanently suspend payment of some thirty million dollars (A321a-322a) to metropolitan area hospitals is also subject to review.

Similarly, in Kingsbrook Jewish Medical Center, the plaintiff hospital maintained two separate health facilities or units, but received reimbursement from HEW on a single unit basis, without regard to the different costs of rendering care at each facility. HEW subsequently reversed its position on Kingsbrook's reimbursement and permitted reimbursement based upon the separate cost per patient at each of the hospital's units. The Secretary refused to make this determination and modification retroactive, however, and the hospital appealed.

The statute pursuant to which the Secretary formulated the hospital's reimbursement method, 42 U.S.C. 1395x(v)(1)(A), authorized the Secretary to promulgate regulations which

may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis [and] may provide for using different methods in different circumstances.... (emphasis supplied)

While this statute appears to vest the Secretary with broad discretion in the promulgation of regulations to determine payment rates to hospitals under the Medicare program, this was not a bar to judicial review of the Secretary's refusal to apply the separate unit reimbursement rates retroactively.

The decision in Kingsbrook to permit the action to proceed makes clear that the Secretary's determinations affecting rates of reimbursement are reviewable in the District Court, notwithstanding the exception to reviewability contained in 5 U.S.C. 701(a)(2).

CONCLUSION

For the reasons stated above, the Order of the District Court dismissing the complaint should be reversed.

Respectfully submitted,

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